The Challenges

of

Medicare and Medicaid

Presented To

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By

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Mr. Chairman and members of the Budget Committee: Thank you for inviting me to appear before you. My name is Gail Wilensky. I am a senior fellow at Project HOPE, an international health education foundation. I have previously served as the Administrator of the Health Care Financing Administration (now the Center for Medicare and Medicaid Services) and also chaired the Medicare Payment Advisory Commission. My testimony today reflects my views as an economist and a health policy analyst as well as my experiences at HCFA and MedPAC. I am not here in any official capacity and should not be regarded as representing the views of Project HOPE.

The purpose of my testimony is to consider some of the challenges resulting from our medical care entitlements, Medicare and Medicaid. While most of the attention in Washington is currently focused on 2006 budgetary issues, the challenges from the entitlement programs grow even larger over time. My comments will reflect some of the short term challenges from the entitlements as well as longer-term challenges. The bulk of my testimony will be on the Medicare program but I will also include some observations about the Medicaid program.

Medicare's Short Term Issues

The president's budget provides for $346 billion in outlays, which represents an increase of $50 billion or 17 percent over last year. For the period 2001-2006, outlays will rise at an average annual rate increase of 9.7%. Since the full drug benefit resulting from the Medicare Modernization Act begins in January of 2006, it is not surprising that most of the focus of this year's Medicare budget is on implementing the new drug benefit and that the budget includes a request for implementation funds. As a former HCFA Administrator, I have observed that including implementation funds is an aspect of new legislation that has been all too frequently overlooked and I commend the Congress for including it in the MMA.

The Congressional Budget Office recently released its projections for the 10 year period, 2006 through 2015. According to CBO, Medicare spending is expected to grow at an average rate increase of 9 percent over the ten year period, reaching $766 billion by 2015. Medicare spending which was 2.6 percent of GDP in 2004 is expected to be at 3.9 percent of GDP by 2015. This substantial growth in spending may well be optimistic since it includes several years of reductions in physician fees, which resulted from the sustainable growth rate (SGR) included in the Balanced Budget Act. Since Congress did not let these reductions go into effect for the years 2003, 2004 and 2005, it is not clear how likely the Congress is to let these reductions go into effect over the next few years.

CBO estimates Medicare Part D spending to grow from $47 billion in 2006 which is a partial year ($75 billion in 2007) to $174 billion in 2015, representing 23 percent of Medicare spending by that time. As the Committee is well aware, there has been considerable controversy about the differing estimates of Part D between CMS and CBO. CMS estimated Part D spending at $534 billion for 2004-2013 and CBO estimated $395 billion for that same period. These differences primarily reflected different estimates of the percent that would enroll in the voluntary Part D, the percent of low income seniors that would enroll in Part D and the take-up rate by seniors in the new Medicare Advantage program. The difference, while large in absolute terms, represents slightly less than 3 percent of Medicare spending over the period 2004 through 2013.

More recently, there has been a lot of attention given to the estimates of the cost of Part D for the period 2006 to 2015. The Administration estimates that cost at $720 billion. CBO's estimate of $796 billion is not exactly comparable because it doesn't allow for some of the adjustments included by the CMS actuary. CBO has also recently reiterated that its current estimate of the program costs for 2004 to 2013 remains almost identical to its original estimate.

The reason for the difference in the estimates for 2004 to 2013 and 2006 to 2015 is not very complicated. The first two years of the program involved only the drug discount card program, some low income support and implementation expenses, all of which are relatively low costs. They were in the 10 year estimate made before passage of the bill. The 10 years that start with the next budget, i.e. 2006, lose the first two "cheap" years and add two years at the end. The end years are much more expensive because the full program will have been in force for 8 years and because of medical inflation and increasing numbers of seniors. There are a lot of difficult issues to face in Medicare but this difference in numbers is not one of them. However, what these numbers do very effectively is to give a glimpse of the true 10 year costs of the new drug benefit which will only continue to increase over time.

Medicare's Longer Term Issues

The longer term financial challenges to Medicare are documented annually in the annual report of the Social Security and Medicare Board of Trustees. While we are only about two months from the 2005 report, the 2004 report lays out the issues sufficiently clearly for the purpose at hand. According to their intermediate projections, which includes a medical inflation factor less than the rate experienced, Medicare expenditures will grow to 7.7 percent of GDP by 2035. Medicare's expenditures are currently smaller than Social Security but Medicare costs are expected to exceed those for Social Security by 2024. Looking over the long haul, the full unfunded liability of Medicare has been estimated to be as high as $28 trillion, $8 trillion of which is attributable to the new drug benefit.

The HI Trust Fund, which covers Part A of Medicare (inpatient hospital, nursing home and some home health care) and frequently receives the most attention from the public, is projected to exhaust its assets by 2019. HI assets are estimated to decline to 89 percent of annual expenditures by 2013, which would no longer meet the Trustees' test of short range financial adequacy.

In many ways, however, the greater concern should be with the impact of Part B Medicare (which covers outpatient hospital, physician, lab and DME) and Part D (the new Prescription Drug benefit). There is not the same concern about insolvency that there is for Part A but rather the impact that the growth in these two areas will have on the budget and the Treasury. The reason is that Parts B and D are financed partly by premiums and co-payments by the elderly but mostly from general revenue.

As a result of this concern, the Medicare Modernization Act requires that the Trustees monitor when they estimate general revenue funding of Medicare will exceed 45 percent of total Medicare outlays and to report if this will occur within the first 7 years of projections. Since

CMS has just reported that Part A costs were lower than expected in 2004 and Part B costs were somewhat higher than expected, there is great interest to see if this will occur with the 2005 report.

No Easy Answers for Medicare

Diagnosing the problem with Medicare is much easier than finding viable solutions. There are several pressures that are driving up spending projections, including but not limited to the impending retirement of the baby-boomers. As all of you know, some 78 million baby-boomers will start turning 65 in 2011 and continue reaching retirement age over the next twenty years. This will double the over 65 population currently covered by Medicare.

But it is not just the increasing numbers of individuals who will be eligible for Medicare that becomes the issue. Those reaching 65 can be expected to experience increased longevity which means they will be on Medicare for longer periods of time than their predecessors. And almost as important, the baby-boomers are followed by the "baby-bust" generation, the unusually small numbers of cohorts born the generation after the boomers. This means that just as the ranks of seniors begins to surge, the ratio of workers to support them will begin to decline – a fiscal "double whammy" in the making.

The most obvious types of options -- changing benefits, changing eligibility or changing the financing of Medicare can affect the financial future of Medicare but none are easy—either in their politics or in their economics. An important opportunity was lost when the MMA was passed, providing an important new benefit to seniors, without also substantially modifying Medicare. But in fairness to the Congress and the Administration, I do not believe there was the political will at that time to take on these difficult issues. An important and little noticed component of the MMA is the provision that substantially reduces the Part B subsidy for higher-income seniors starting 2007, which could provide an important precedent for introducing other provisions that relate government contributions or subsidies to the income and/or wealth of baby-boomers.

Two others areas may offer the potential to ease future financial burdens from Medicare and need to be explored further. The first is to rethink the whole concept of retirement and the second, is to find ways to "spend smarter."

Rethinking Retirement

The notion of thinking about pensions or Social Security and Medicare as joint programs for retirees is not a new concept but has received renewed attention following a recent mentioning of it by Chairman Thomas of the Ways and Means Committee. This doesn't make the reform of Social Security and Medicare any easier but may lead to better results.

Even more important, is the need to reconsider retirement at age 65 as the norm. As you probably are aware, the choice of age 65 as an expected retirement age occurred at a time when longevity was far less than it is at present and when the disability rates of those who survived into their sixties and seventies was far greater than it is today. Social Security is in the process of

moving from age 65 to age 67 for full benefits, still an age where the time in retirement could approach 40 percent or more of the time spent in the work force.

While there has been some increase in the numbers of people over age 50 that expect to spend some time in their sixties and even seventies working, it is hardly the norm. Changing this expectation would require changes in fiscal policies as well as cultural expectations regarding retirement in order to encourage continued and more flexible labor force participation. The scarcity of new labor force entrants, associated with the baby bust generation should encourage employers to be more creative in their treatment of seniors just as they were with their employment of women in the 1970's and 1980's. But it is important to make sure that fiscal and other government policies are supportive of continued labor force participation as well.

Spending Smarter

Finally, if the United States can learn to spend smarter in health care, through strategies involving pay-for-performance, health IT, electronic medical records, and importantly, changes in the tax code, it may be possible to reduce the growth in health care spending to rates that are below their historic averages. This will only happen, if these changes occur in all sectors of health care and not just in Medicare.

To no surprise, over long periods of time, Medicare tracks the rest of health care spending pretty closely. First, seniors spend substantially more per person than the younger population which means that even when they represented only 12 percent of the population, they accounted for a disproportionate share of spending on health care. As seniors become close to 25 percent of the population, they will have an even bigger effect on overall spending levels. Secondly, their relative growth in numbers combined with their high voting participation rates, will give them even greater political clout than they have had in the past. It is difficult to imagine this powerful group tolerating a health care system that was in any important way "lesser than" what exists for the rest of the population.

"Spending smarter" is a theme that has received at lot of attention lately. While it seems pretty clear that we can and should have better information on relative cost-effectiveness and clinical-effectiveness of alternative therapies and procedures as well as better incentives for both patients and providers, not much is known on whether this will slow rates of spending growth relative to historic averages or just provide better value for the money spent. Similarly, introducing information systems in health care and making the information side approach the sophistication of the device and procedure side of medicine should provide substantial one-time savings. Whether these changes would reduce rates of spending over time is less clear. However, given the alternatives to slowing spending otherwise available, improving information and incentives, changes to the tax code and adopting modern information systems seems the most promising strategy available.

Medicaid

Although Medicaid represents a somewhat different set of issues, the sustained impact of a growing Medicaid program has some similar effects on the budgetary pressures which will be

felt by the Federal government. The Federal share of Medicaid spending has increased from $129 billion in 2001 to $193 billion for 2006, an average annual increase of 8.3 percent. The CBO predicts that Medicaid will grow at an average rate of 8.7 percent through 2015, reaching $392 billion for the Federal share by 2015.

It is important to consider the effects of Medicaid along with those of Medicaid for several reasons. First, the budgetary effects are significant and the growth rates not dissimilar. Projections by CBO have indicated that if Medicare and Medicaid were to continue to grow at a rate of 2 percentage points faster than the GDP, which is close to its historic average, these two programs would account for 20 percent of the GDP by 2040, the approximate current share represented by the entire Federal budget. If the rates of growth were reduced to GDP plus one, spending on these two entitlements would approximate 12 percent of GDP. Thus, the need to think hard about ways to slow their growth rate is crucial.

The second reason it is important to think about Medicare and Medicaid together is that the majority of expenditures go to the aged and disabled populations even if the majority of Medicaid participants are neither aged nor disabled. A recent study by the Urban Institute indicated that much of the growth in Medicaid spending from 2000 to 2003 was attributable to a growth in enrollment. While that might not sound so surprising since much of that period was characterized by slow job growth coming out of a recession, less attention has been given to the fact that even here, a majority of the spending growth was attributable to the aged and disabled. This was true even though the numbers of aged and disabled were growing more slowly than the numbers in families.

So much of the experimentation with finding more efficient (or just cheaper) ways to provide in the past has focused on families and not on the aged and disabled but it is the latter two groups that represent the majority of spending and also spending growth. Hopefully some of the flexibility that the Administration is proposing for the provision of long term care services for the elderly and disabled will help spur the state's creativity in these areas.

The states' creativity raises another issue important to a better understanding of Medicaid spending growth. When pressed financially, states have shown substantial creativity in finding ways to increase Federal dollars without a concomitant increase in their own spending. Sometimes the increased spending has gone into additional spending on Medicaid or other health care programs and sometimes not. In either case, a program that relies on state matching as the primary mechanism for cost control cannot function if the states' are not contributing their appropriate shares. I applaud the Administration for introducing a series of steps to make sure the states are contribution their legally determined match including restricting intergovernmental transfers and Medicaid payments that are in excess of actual costs of services.

On a broader level, the time is long overdue to rethink the type of program for low-income populations that makes sense for the 21st Century. The current program leaves out many very poor individuals, covers some who are very substantially above poverty, provides very uncoordinated care to the so-called "dual-eligibles" who are on both Medicare and Medicaid and

provides very little information on the impact that Medicaid and SCHIP has had on the health status of the low income populations being served.

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